Children's Community Physicians Association (CCPA) uses the Illinois Department of Public Health's (IDPH) Health Care Professional Credentialing and Business Data Gathering Form (IL application) as the official initial credentialing application for the CCPA credentialing process. Please view detail instructions below on how to complete each section of the IL application.

Getting Started

To complete the IL application, you will need the support documents listed below. Please note you are required to submit your support documents to CCPA along with the IL application.

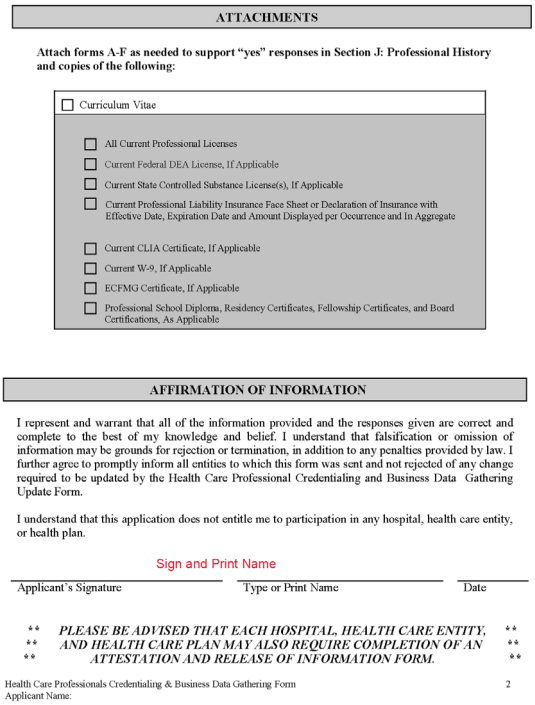
- ☐ All Current Professional License(s)
- ☐ Current Federal D.E.A. Certificate
- ☐ Current State Controlled Substance Certificate(s)
- ☐ Current Certificate of Insurance
- ☐ ECFMG Certificate (if applicable)
- ☐ Copies of Diploma(s), Residency Certificate(s), Fellowship Certificate(s) as applicable
- ☐ Current Curriculum Vitae
- ☐ Board Certification Certificate or Letter from ABP with Effective Date

IDPH Health Care Professional Credentialing and Business Gathering Form

The sections highlighted in yellow or green or outlined in red are to be filled out in its entirely if applicable.

Affirmation of Information – pg. 2

Page two (2) of the IL application is affirming that all the information listed on the application is complete and true to the best of your knowledge. Once this page is signed and submitted to CCPA, the applicant is the only person who can make changes to the IL application. See Figure 1.



ATTACHMENTS

Attach forms A-F as needed to support "yes" responses in Section J: Professional History and copies of the following:

- ☐ Curriculum Vitae
- ☐ All Current Professional Licenses
- ☐ Current Federal DEA License, If Applicable
- ☐ Current State Controlled Substance License(s), If Applicable
- ☐ Current Professional Liability Insurance Face Sheet or Declaration of Insurance with Effective Date, Expiration Date and Amount Displayed per Occurrence and In Aggregate
- ☐ Current CLIA Certificate, If Applicable
- ☐ Current W-9, If Applicable
- ☐ ECFMG Certificate, If Applicable
- ☐ Professional School Diploma, Residency Certificates, Fellowship Certificates, and Board Certifications, As Applicable

AFFIRMATION OF INFORMATION

I represent and warrant that all of the information provided and the responses given are correct and complete to the best of my knowledge and belief. I understand that falsification or omission of information may be grounds for rejection or termination, in addition to any penalties provided by law. I further agree to promptly inform all entities to which this form was sent and not rejected of any change required to be updated by the Health Care Professional Credentialing and Business Data Gathering Update Form.

I understand that this application does not entitle me to participation in any hospital, health care entity, or health plan.

Sign and Print Name

Applicant's Signature | Type or Print Name | Date

** *PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTITY, AND HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN ATTESTATION AND RELEASE OF INFORMATION FORM.* **

Health Care Professionals Credentialing & Business Data Gathering Form 2
Applicant Name:

Figure 1 - IL App. Pg. 2

Chapter A: Practice and Professional Information – pg. 3

Page three (3) is the collection of general information about the physician. All areas of this section must be completed, even the *CONFIDENTIAL INFORMATION* section. If there is information on this page that you do not want to include because you are emailing it to CCPA. Please call a CCPA team member and they will take the sensitive information over the telephone. See Figure 2.

Fill out page completely, including the confidential information box.

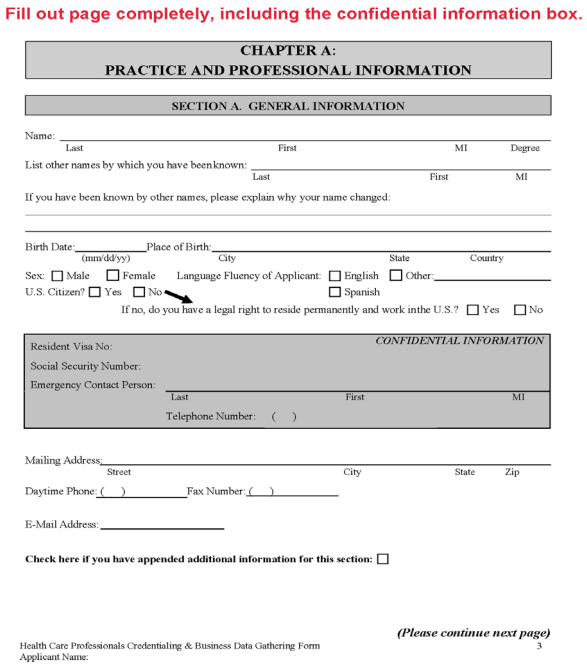


Figure 2 - IL App. Pg. 3

Section B. Professional Information pgs. 4 - 6

Section B of the application is for IL professional license, DEA, and state control substance information. All Indiana physicians, who do not have an IL professional license, please add you state professional license information in the *Current and Previous Professional License(s) in Other States.*
Please note, if you list other state licenses on your application, submit a copy of the corresponding license in your completed application packet. See Figure 3.

Fill this section out if practicing in Indiana.

Complete for each *Specialty Section*, please be sure to answer the question about when you are taking the boards certification test if you currently are not board certified.

Note: if you have failed your board test, answer yes to question #8 on the *Disclosure Question* page 19 and complete Form A. See Figures 4-6.

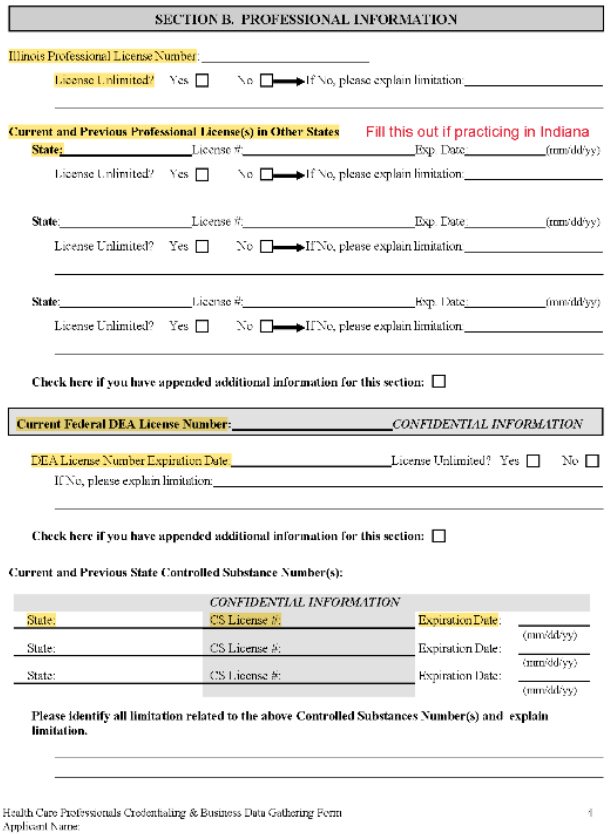
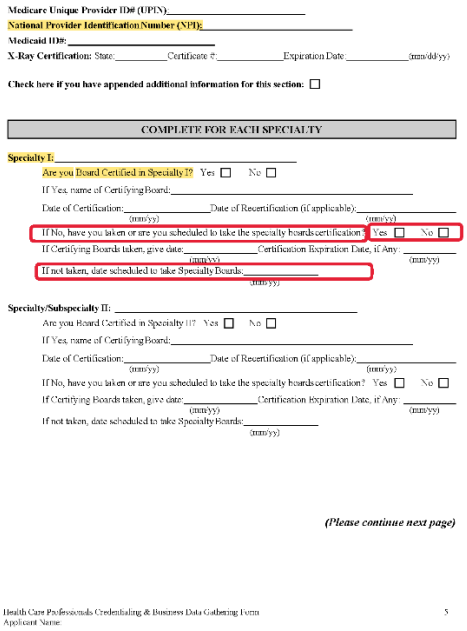


Figure 3 - IL app Pg. 4



Medicare Unique Provider ID# (UPIN):_____
National Provider Identification Number (NPI):_____
Medicaid ID#: _____
X-Ray Certification: State:_____Certificate #:_____Expiration Date:_____(mm/dd/yy)

Check here if you have appended additional information for this section: ☐

COMPLETE FOR EACH SPECIALTY

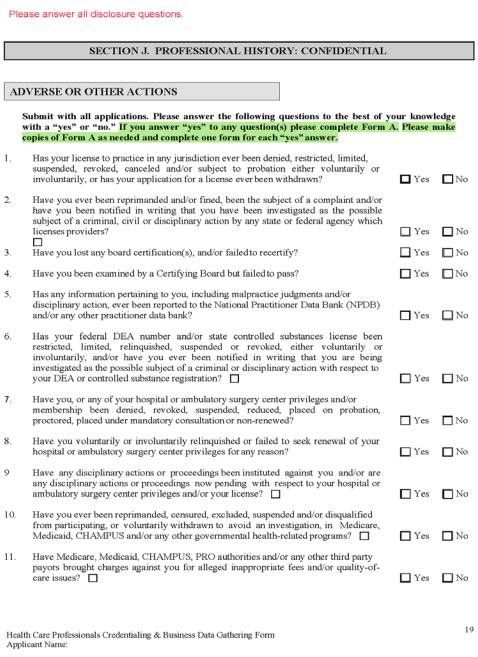
Specialty I: _____
Are you Board Certified in Specialty I? Yes ☐ No ☐
If Yes, name of Certifying Board: _____
Date of Certification: _____(mm/yy) Date of Recertification (if applicable): _____(mm/yy)
If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐
If Certifying Boards taken, give date: _____(mm/yy) Certification Expiration Date, if Any: _____(mm/yy)
If not taken, date scheduled to take Specialty Boards: _____(mm/yy)

Specialty/Subspecialty II: _____
Are you Board Certified in Specialty II? Yes ☐ No ☐
If Yes, name of Certifying Board: _____
Date of Certification: _____(mm/yy) Date of Recertification (if applicable): _____(mm/yy)
If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐
If Certifying Boards taken, give date: _____(mm/yy) Certification Expiration Date, if Any: _____(mm/yy)
If not taken, date scheduled to take Specialty Boards: _____(mm/yy)

(Please continue next page)

Health Care Professionals Credentialing & Business Data Gathering Form 5
Applicant Name:

Figure 4 - IL app Pg. 5



Please answer all disclosure questions.

SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL

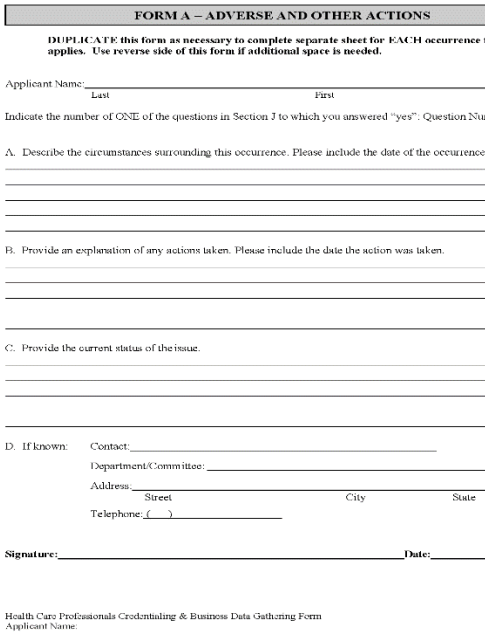
ADVERSE OR OTHER ACTIONS

Submit with all applications. Please answer the following questions to the best of your knowledge with a "yes" or "no." If you answer "yes" to any question(s) please complete Form A. Please make copies of Form A as needed and complete one form for each "yes" answer.

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? ☐ Yes ☐ No
2. Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers? ☐ ☐ Yes ☐ No
3. Have you lost any board certification(s), and/or failed to recertify? ☐ Yes ☐ No
4. Have you been examined by a Certifying Board but failed to pass? ☐ Yes ☐ No
5. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank? ☐ Yes ☐ No
6. Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration? ☐ Yes ☐ No
7. Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed? ☐ Yes ☐ No
8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? ☐ Yes ☐ No
9. Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license? ☐ Yes ☐ No
10. Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs? ☐ Yes ☐ No
11. Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues? ☐ Yes ☐ No

Health Care Professionals Credentialing & Business Data Gathering Form 19
Applicant Name:

Figure 5 - IL App Pg. 19



FORM A – ADVERSE AND OTHER ACTIONS

DUPLICATE this form as necessary to complete separate sheet for EACH occurrence t applies. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First

Indicate the number of ONE of the questions in Section J to which you answered "yes". Question Nu

A. Describe the circumstances surrounding this occurrence. Please include the date of the occurrence

B. Provide an explanation of any actions taken. Please include the date the action was taken.

C. Provide the current status of the issue.

D. If known: Contact: _____
Department/Committee: _____
Address: _____
Street City State
Telephone: (___) _____

Signature: _____ **Date:** _____

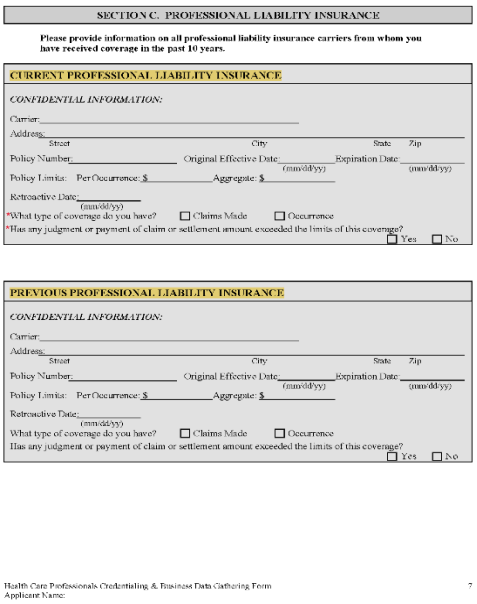
Health Care Professionals Credentialing & Business Data Gathering Form
Applicant Name:

Figure 6 - Form A

Section C: Professional Liability Insurance pgs. 7-8

Section C requires that you list the malpractice insurance coverage that you had over the last ten (10) years (current and previous).

If you have been denied or voluntarily relinquished your professional liability insurance coverage, and/or had your professional liability insurance coverage canceled, non-renewed or limits reduced, please answers the *Liability Insurance* section questions on page 20. If you answer yes to any question, please complete Form C. See Figures 7-9.



SECTION C. PROFESSIONAL LIABILITY INSURANCE

Please provide information on all professional liability insurance carriers from whom you have received coverage in the past 10 years.

CURRENT PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier:_____

Address:_____
Street City State Zip

Policy Number:_____ Original Effective Date:_____ (mm/dd/yy) Expiration Date:_____ (mm/dd/yy)

Policy Limits: Per Occurrence: $_____ Aggregate: $_____

Retroactive Date:_____ (mm/dd/yy)

*What type of coverage do you have? ☐ Claims Made ☐ Occurrence

*Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage? ☐ Yes ☐ No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier:_____

Address:_____
Street City State Zip

Policy Number:_____ Original Effective Date:_____ (mm/dd/yy) Expiration Date:_____ (mm/dd/yy)

Policy Limits: Per Occurrence: $_____ Aggregate: $_____

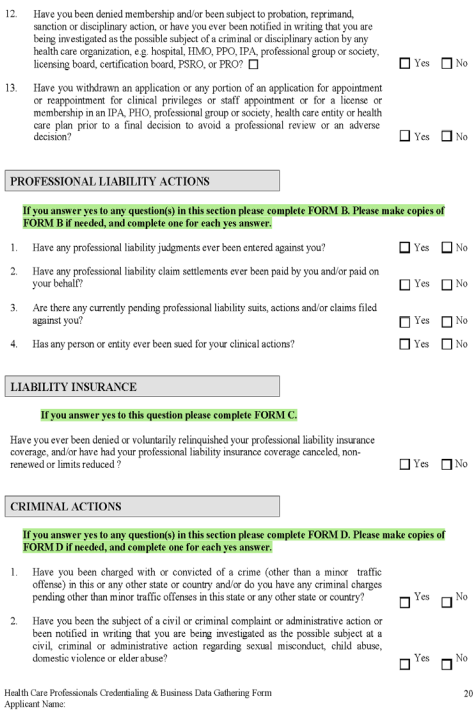
Retroactive Date:_____ (mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage? ☐ Yes ☐ No

Health Care Professionals Credentialing & Business Data Gathering Form 7
Applicant Name:

Figure 7- IL App. Pg. 7



12. Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO? ☐ ☐ Yes ☐ No

13. Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision? ☐ Yes ☐ No

PROFESSIONAL LIABILITY ACTIONS

If you answer yes to any question(s) in this section please complete FORM B. Please make copies of FORM B if needed, and complete one for each yes answer.

1. Have any professional liability judgments ever been entered against you? ☐ Yes ☐ No
2. Have any professional liability claim settlements ever been paid by you and/or paid on your behalf? ☐ Yes ☐ No
3. Are there any currently pending professional liability suits, actions and/or claims filed against you? ☐ Yes ☐ No
4. Has any person or entity ever been sued for your clinical actions? ☐ Yes ☐ No

LIABILITY INSURANCE

If you answer yes to this question please complete FORM C.

Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, and/or have had your professional liability insurance coverage canceled, non-renewed or limits reduced ? ☐ Yes ☐ No

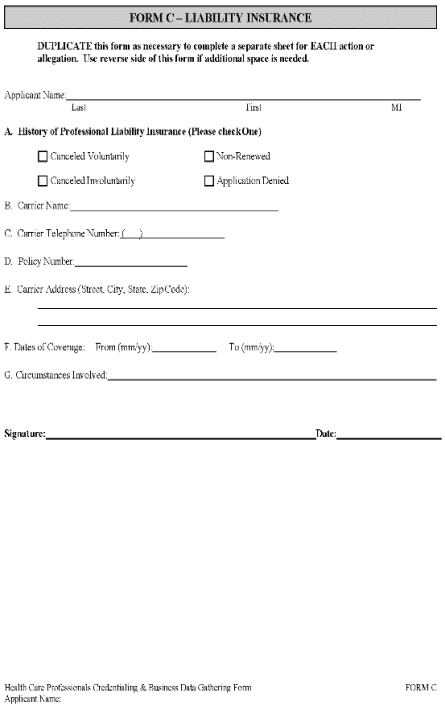
CRIMINAL ACTIONS

If you answer yes to any question(s) in this section please complete FORM D. Please make copies of FORM D if needed, and complete one for each yes answer.

1. Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country? ☐ Yes ☐ No
2. Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse? ☐ Yes ☐ No

Health Care Professionals Credentialing & Business Data Gathering Form 20
Applicant Name:

Figure 8- IL App. Pg. 20



FORM C – LIABILITY INSURANCE

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name:_____
Last First MI

A. History of Professional Liability Insurance (Please check One)

☐ Canceled Voluntarily ☐ Non-Renewed

☐ Canceled Involuntarily ☐ Application Denied

B. Carrier Name:_____

C. Carrier Telephone Number: (___)_____

D. Policy Number:_____

E. Carrier Address (Street, City, State, Zip Code):

_____

_____

F. Dates of Coverage: From (mm/yy):_____ To (mm/yy):_____

G. Circumstances Involved:_____

Signature:_____ **Date:**_____

Health Care Professionals Credentialing & Business Data Gathering Form FORM C
Applicant Name:

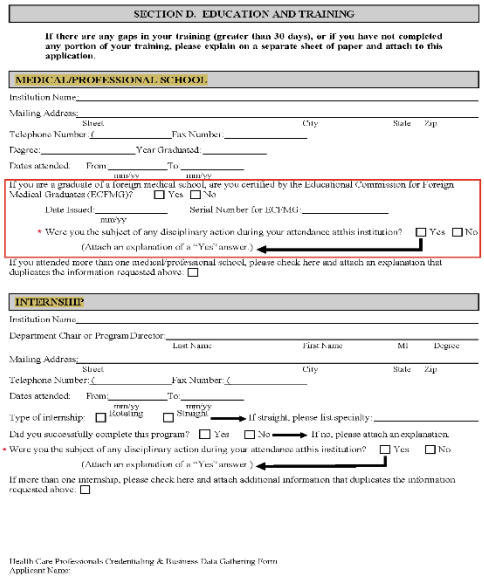
Figure 9 - IL App. Form C

Section D: Education and Training pgs. 9-12

Section D. requires that you complete all sections that relates to your education and training. A signed and dated letter explaining a gap in your training of more than 30-days is required. Please submit the letter with your completed application.

All initial credentialing applications requires the applicant to submit a copy of their medical degree and residency certificate.

If you answer yes to graduating from a foreign medical school and are certified by the Educational Commission for Foreign Medical Graduates (ECFMG), please include a copy of your ECFMG certificate with the completed IL application. See Figure 10.



SECTION D. EDUCATION AND TRAINING

If there are any gaps in your training (greater than 30 days), or if you have not completed any portion of your training, please explain on a separate sheet of paper and attach to this application.

MEDICAL/PROFESSIONAL SCHOOL

Institution Name:

Mailing Address:
Street City State Zip

Telephone Number: ( ) Fax Number: ( )

Degree: Year Graduated:

Dates attended: From: mm/yy To: mm/yy

If you are a graduate of a foreign medical school, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No

Date Issued: mm/yy Serial Number for ECFMG:

* Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No
(Attach an explanation of a "Yes" answer.)

If you attended more than one medical/professional school, please check here and attach an explanation that duplicates the information requested above. ☐

INTERNSHIP

Institution Name:

Department Chair or Program Director:
Last Name First Name MI Degree

Mailing Address:
Street City State Zip

Telephone Number: ( ) Fax Number: ( )

Dates attended: From: mm/yy To: mm/yy

Type of internship: ☐ Rotating ☐ Straight → If straight, please list specialty:

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

* Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No
(Attach an explanation of a "Yes" answer.)

If more than one internship, please check here and attach additional information that duplicates the information requested above. ☐

Health Care Professionals Credentialing & Business Data Gathering Form
Applicant Name:

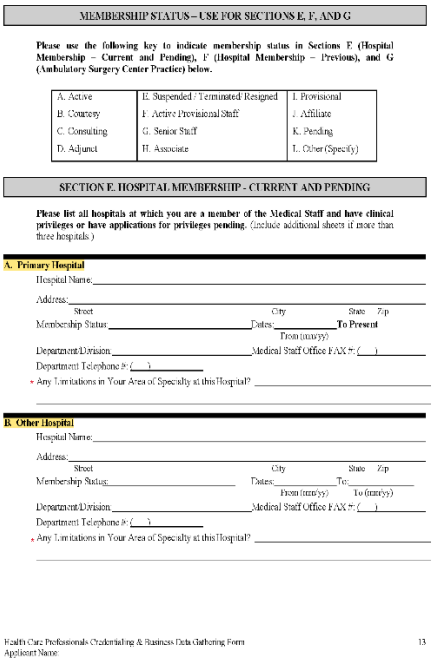
Figure 10 - IL App. Pg. 9

Membership Status – Use for Sections E, F, and G - pgs. 13-15

Please complete all the sections in the hospital membership status areas as it pertains to your current and previous privileges. **Note:** this does not include your hospital membership during your internship/residency and or fellowship.

If you have voluntarily or involuntarily relinquished or failed to seek renewal of your hospital privileges for any reason. Please answer question #8 on page 19 of Section J. and complete Form A. See Figures 11 – 14.

Section F: Fill out this section if you have held any previous hospital privileges.



MEMBERSHIP STATUS – USE FOR SECTIONS E, F, AND G

Please use the following key to indicate membership status in Sections E (Hospital Membership – Current and Pending), F (Hospital Membership – Previous), and G (Ambulatory Surgery Center Practice) below.

A. Active	E. Suspended / Terminated/ Resigned	I. Provisional
B. Courtesy	F. Active Provisional Staff	J. Affiliate
C. Consulting	G. Senior Staff	K. Pending
D. Adjunct	H. Associate	L. Other (Specify)

SECTION E. HOSPITAL MEMBERSHIP - CURRENT AND PENDING

Please list all hospitals at which you are a member of the Medical Staff and have clinical privileges or have applications for privileges pending. (include additional sheets if more than three hospitals.)

A. Primary Hospital

Hospital Name:

Address:
Street City State Zip

Membership Status: Dates: To Present
From (mm/yy)

Department/Division: Medical Staff Office FAX #: ( )

Department Telephone #: ( )

* Any Limitations in Your Area of Specialty at this Hospital?

B. Other Hospital

Hospital Name:

Address:
Street City State Zip

Membership Status: Dates: To:
From (mm/yy) To (mm/yy)

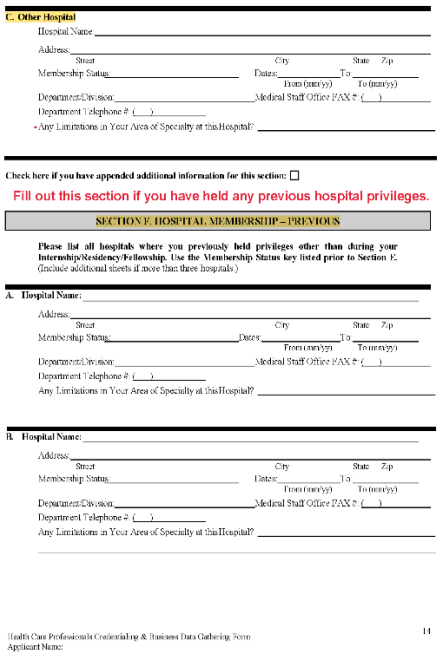
Department/Division: Medical Staff Office FAX #: ( )

Department Telephone #: ( )

* Any Limitations in Your Area of Specialty at this Hospital?

Health Care Professionals Credentialing & Business Data Gathering Form 13
Applicant Name:

Figure 11 - IL App. Pg. 13



C. Other Hospital

Hospital Name _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ To _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: (___) _____

Department Telephone #: (___) _____

Any Limitations in Your Area of Specialty at this Hospital? _____

Check here if you have appended additional information for this section: ☐

Fill out this section if you have held any previous hospital privileges.

SECTION E. HOSPITAL MEMBERSHIP – PREVIOUS

Please list all hospitals where you previously held privileges other than during your Internship/Residency/Fellowship. Use the Membership Status key listed prior to Section E. (Include additional sheets if more than three hospitals.)

A. Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ To _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: (___) _____

Department Telephone #: (___) _____

Any Limitations in Your Area of Specialty at this Hospital? _____

B. Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ To _____
From (mm/yy) To (mm/yy)

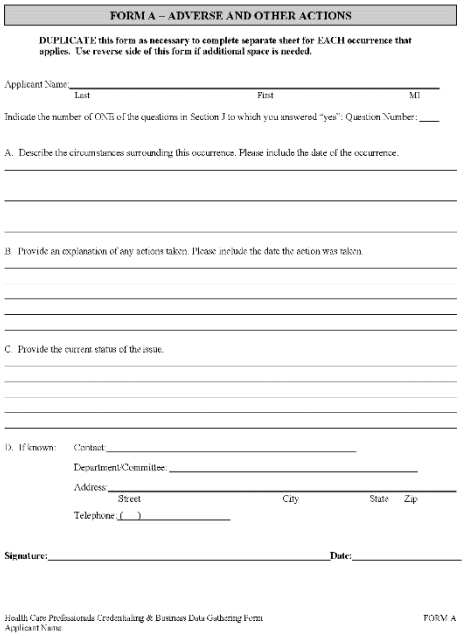
Department/Division: _____ Medical Staff Office FAX #: (___) _____

Department Telephone #: (___) _____

Any Limitations in Your Area of Specialty at this Hospital? _____

Health Care Professionals Credentialing & Business Data Gathering Form 14
Applicant Name:

Figure 12 - IL App. Pg. 14



FORM A – ADVERSE AND OTHER ACTIONS

DUPLICATE this form as necessary to complete separate sheet for EACH occurrence that applies. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

Indicate the number of ONE of the questions in Section J to which you answered "yes": Question Number: ____

A. Describe the circumstances surrounding this occurrence. Please include the date of the occurrence.

B. Provide an explanation of any actions taken. Please include the date the action was taken.

C. Provide the current status of the issue.

D. If known: Contact: _____

Department/Committee: _____

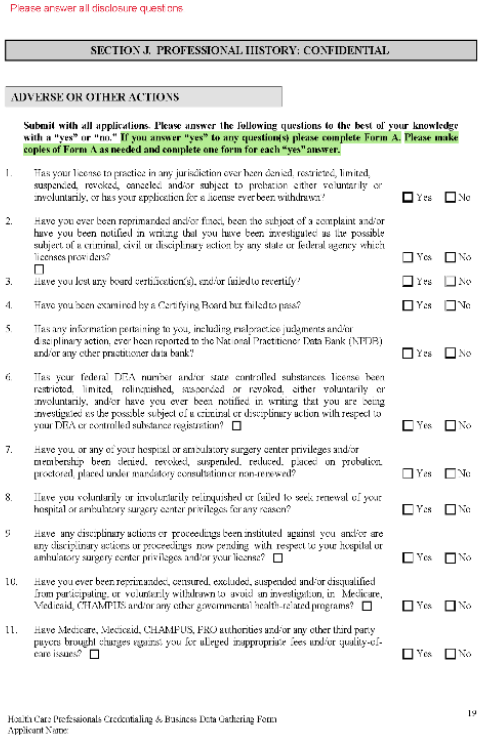
Address: _____
Street City State Zip

Telephone: (___) _____

Signature: _____ Date: _____

Health Care Professionals Credentialing & Business Data Gathering Form FORM A
Applicant Name:

Figure 13 - IL App. Form A



Please answer all disclosure questions

SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL

ADVERSE OR OTHER ACTIONS

Submit with all applications. Please answer the following questions to the best of your knowledge with a "yes" or "no." If you answer "yes" to any question(s) please complete Form A. Please make copies of Form A as needed and complete one form for each "yes" answer.

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, cancelled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? ☐ Yes ☐ No

2. Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers? ☐ ☐ Yes ☐ No

3. Have you lost any board certification(s), and/or failed to recertify? ☐ Yes ☐ No

4. Have you been examined by a Certifying Board but failed to pass? ☐ Yes ☐ No

5. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank? ☐ Yes ☐ No

6. Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration? ☐ ☐ Yes ☐ No

7. Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed? ☐ Yes ☐ No

8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? ☐ Yes ☐ No

9. Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license? ☐ ☐ Yes ☐ No

10. Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in: Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs? ☐ ☐ Yes ☐ No

11. Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payers brought charges against you for alleged inappropriate fees and/or quality-of-care issues? ☐ ☐ Yes ☐ No

Health Care Professionals Credentialing & Business Data Gathering Form 19
Applicant Name:

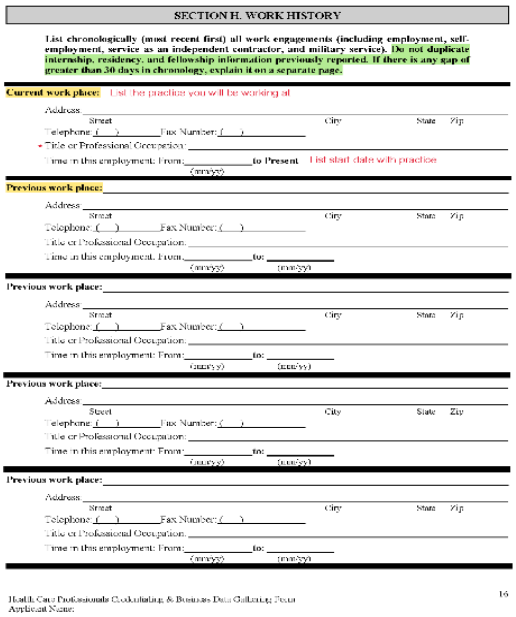
Figure 14 - IL App. Pg. 19

Section H: Work History – pgs. 16 – 17

Add your current work history (list the practice you are joining along with the start date). Include previous workplace, do not include your internship, residency, or fellowship information. If you have a 30-day or more gap in your work history, please sign and date a letter explaining the gap between employments. See Figure 15.

The dates of employments should include the month and year. Example: *From: 01/1977 to: 10/1984*. The dates on your CV should also be listed in the month/year format for your school and employment history.

List the practice you will be working at and the start date.



SECTION H. WORK HISTORY

List chronologically (most recent first) all work engagements (including employment, self-employment, service as an independent contractor, and military service). Do not duplicate internship, residency, and fellowship information previously reported. If there is any gap of greater than 30 days in chronology, explain it on a separate page.

Current work place: List the practice you will be working at

Address: Street City State Zip

Telephone: ( ) Fax Number: ( )

Title or Professional Occupation:

Time in this employment: From: (mm/yy) to Present List start date w/in practice

Previous work place:

Address: Street City State Zip

Telephone: ( ) Fax Number: ( )

Title or Professional Occupation:

Time in this employment: From: (mm/yy) to: (mm/yy)

Previous work place:

Address: Street City State Zip

Telephone: ( ) Fax Number: ( )

Title or Professional Occupation:

Time in this employment: From: (mm/yy) to: (mm/yy)

Previous work place:

Address: Street City State Zip

Telephone: ( ) Fax Number: ( )

Title or Professional Occupation:

Time in this employment: From: (mm/yy) to: (mm/yy)

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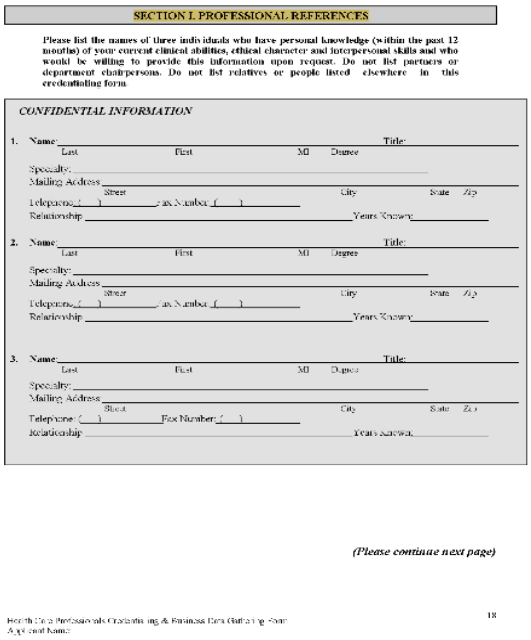
Figure 15 - IL App. Pg. 16

Section I: Professional References pg. 18

List three physicians who in the last twelve months has personal knowledge of your current clinical abilities, ethical character, and interpersonal skills. Include all the information requested along with email addresses for each person. See Figure 16.



SECTION I. PROFESSIONAL REFERENCES

Please list the names of three individuals who have personal knowledge (within the past 12 months) of your current clinical abilities, ethical character and interpersonal skills and who would be willing to provide this information upon request. Do not list partners or department chairpersons. Do not list relatives or people listed elsewhere in this credentialing form.

CONFIDENTIAL INFORMATION

1. **Name:** Last First MI Degree **Title:**
Specialty:
Mailing Address: Street City State Zip
Telephone: ( ) Fax Number: ( )
Relationship: Years Known:

2. **Name:** Last First MI Degree **Title:**
Specialty:
Mailing Address: Street City State Zip
Telephone: ( ) Fax Number: ( )
Relationship: Years Known:

3. **Name:** Last First MI Degree **Title:**
Specialty:
Mailing Address: Street City State Zip
Telephone: ( ) Fax Number: ( )
Relationship: Years Known:

(Please continue next page)

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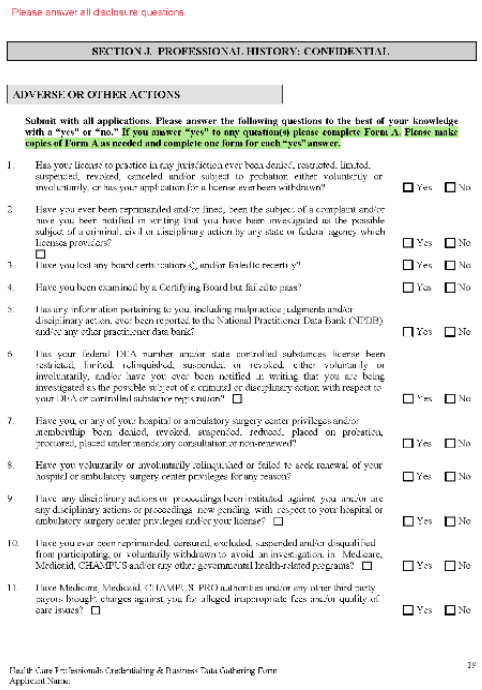
Figure 16 - IL App. Pg. 18

Section J: Professional History Confidential pgs. 19-21

Answer all the questions with a yes or no. If you answer yes to any of the questions, please complete a corresponding Form A – F. All forms can be found at the end of the application. See Figure 17.

Please answer all disclosure questions.



Please answer all disclosure questions.

SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL

ADVERSE OR OTHER ACTIONS

Submit with all applications. Please answer the following questions to the best of your knowledge with a "yes" or "no." If you answer "yes" to any question(s) please complete Form A. Please make copies of Form A as needed and complete one form for each "yes" answer.

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? ☐ Yes ☐ No
2. Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers? ☐ Yes ☐ No
3. Have you lost any board certifications, and/or failed to recertify? ☐ Yes ☐ No
4. Have you been examined by a Certifying Board but failed to pass? ☐ Yes ☐ No
5. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank? ☐ Yes ☐ No
6. Has your federal DEA number and/or state controlled substances license been restricted, forfeited, relinquished, suspended, or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration? ☐ ☐ Yes ☐ No
7. Have you or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed? ☐ Yes ☐ No
8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? ☐ Yes ☐ No
9. Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license? ☐ ☐ Yes ☐ No
10. Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs? ☐ ☐ Yes ☐ No
11. Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality of care issues? ☐ ☐ Yes ☐ No

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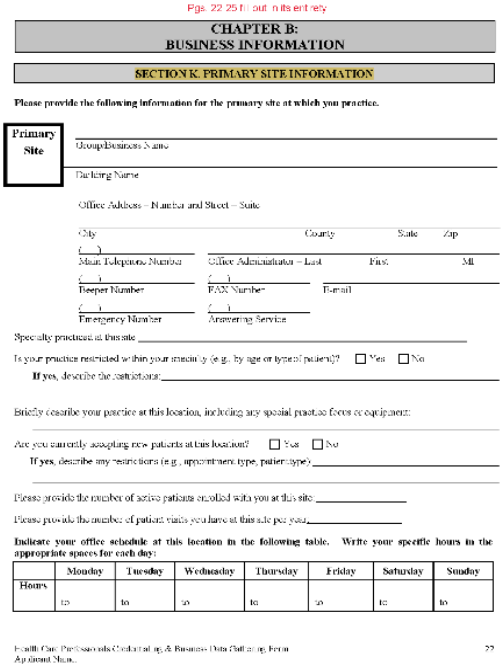
Figure 17 - IL App. Pg. 19

Chapter B: Business Information Section K Primary Site Information pgs. 22-29

Fill out the business portion in its entirety. There is a section for primary site and any additional sites where you will provide treatment that is own by the practice. This information is used for linking physicians to managed care contracts. See Figure 18.



Pgs. 22-25 Fill out in its entirety

CHAPTER B:
BUSINESS INFORMATION

SECTION K: PRIMARY SITE INFORMATION

Please provide the following information for the primary site at which you practice.

Primary Site

Group/Business Name

Building Name

Office Address – Number and Street – Suite

City County State Zip

( ) ( )
Main Telephone Number Office Administrator – Last First MI

( ) ( )
Beeper Number FAX Number E-mail

( ) ( )
Emergency Number Answering Service

Specialty practiced at this site

Is your practice restricted within your specialty (e.g., by age or type of patient)? ☐ Yes ☐ No

If yes, describe the restrictions:

Briefly describe your practice at this location, including any special practice focus or equipment:

Are you currently accepting new patients at this location? ☐ Yes ☐ No

If yes, describe any restrictions (e.g., appointment type, patient type):

Please provide the number of active patients enrolled with you at this site:

Please provide the number of patient visits you have at this site per year:

Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours							
	to	to	to	to	to	to	to

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Applicant Name:

Figure 18 - IL App. Pg. 22

Miscellaneous Things to Know

When correcting/updating any portion of the application, please date and initial near each correction.

Please complete each section to the best of your knowledge.